CHAPTER 4

Empowering nursing and patient-centred healthcare through the systematisation of clinical work

Helen Close and Eileen Scott

In 2001, Alison Kitson wrote a paper entitled 'Nursing leadership: bringing caring back to the future' setting out her vision for the future of the UK health service in 2012. Her key messages were as follows.

- Improvement of health services is dependent upon the way patient-centred care is understood.
- Traditional healthcare culture and roles need to change if service delivery is to improve.
- Leadership that promotes the values of patient-centred care – respect, dignity, compassion caring – will lead this transformation.
- For nursing, the features that will help this transformation are patient-centred care measures developed as part of performance management and clinical governance, leadership based on personal growth and development principles, and a new clinical career and competency framework for nursing.[1]

The implicit recognition here, that an empowered, autonomous nursing workforce and patient-centred care are inextricably interdependent goals, has been an underpinning feature of attempts to make nursing work explicit, planned and systematic since the days of Florence Nightingale. Along a continuum from 'task' through 'team' to 'named nursing', the work of nursing has been organised to make explicit its *content* while at the same time keep largely hidden the contribution it has made to multidisciplinary quality, continuity, and the coordination of the care *process* experienced by the patient.[2]

Despite attempts to make visible and transparent these aspects via the professionalisation of nursing, its continuing subordination has prevented the realisation of Kitson's vision in several ways. First, clinical decision making and longer term decisions about resources remain covert and implicit and outcomes

continue to be largely shaped by the dominant medical perspective.[3] Second, the everyday tension between collective and individual needs is resolved in an ad hoc, covert manner which fails to make explicit the type of 'patient-centred care' that is claimed as an objective. Kitson argues that patient-centred care can only become a reality via a paradigm shift whereby 'caring' is given as great a priority as 'curing' and that 'traditional healthcare culture and roles need to change if service delivery is to improve'.[4]

This chapter explores the role of systematisation, and in particular pathways, in the achievement of this cultural change by allowing nurses to lead the way in articulating the *process* that constitutes the patient journey. Using examples taken from practice, we argue that the need to plan and coordinate collective care and the desire to remain responsive to individual patient needs within the resources available can only be resolved by giving nursing a mechanism, via pathways, with which to renegotiate the power differential between nursing and medicine in such a way that the unique historical contribution of nursing to the systematisation of care delivery is fully recognised.

A HISTORY OF SYSTEMATISATION AND NURSING

The gendered division of labour, in which nursing was seen as the 'natural' expression of the caring nature of women, has long been attributed to the organisation of clinical work in which nurses were the unseen 'handmaidens' to doctors who 'know best'.[5] Accountability was traditionally structured along hierarchical lines in which Matron or Sister juggled the contrasting requirements of several different consultant physicians or surgeons and had ultimate, but largely invisible, control over the apparently seamless patient journey from admission to discharge.[6] That this control was covert, implicit and devolved the practical work of nursing into a series of simple tasks led to concerns about individualised, patient-centred care, patient advocacy, and the individual autonomy of nurses.[7] The professionalisation of nursing was seen as a way of claiming control over these interrelated issues, and systematisation (i.e. the explicit planning of who will do what, how, where and when) was the mechanism for providing the autonomy and individual accountability on which the definition of nursing as a profession depended.[8]

Significantly, the emergence of the 'nursing process' in the 1980s transformed the articulation of nursing work from a simple task-based focus to a process in which collective decisions were explicitly and overtly informed by the specialist knowledge that was seen as nursing's unique contribution to care. For the first time in the history of nursing, the articulation of this process allowed for evaluation of individual contributions to care, thus allowing nursing to lead the way in a concern for measuring quality of care, as well as becoming increasingly accountable for the delivery and management of care.[9] The resultant professionalisation strategy led to the introduction of 'Project 2000' which, via the development of a specialist body of nursing knowledge,

sought to sever the link between nurse education and the handmaiden needs of medicine.[10]

Even long before the introduction of the nursing process, nursing showed an ability to develop ways of providing a systematic approach to the organisation and planning of their work. In various guises and terminology ranging from case management to primary nursing, a commitment to 'systematisation' (i.e. applying a planned, explicit, proactive, coordinated approach to the organisation of nursing work) has been a largely hidden feature of nursing practice since the days of Florence Nightingale. Although these systematic approaches to care went some way to providing visibility about decision making and care delivery, the articulation of that content inherently disregarded the multidisciplinary *process* that characterises the patient journey, both in the community and in a hospital context. This fact has largely conspired to keep the importance of nursing work 'a secret' in regard to the interconnectedness between nursing and medicine.[11] Of particular note here is the implicit, covert historical role of nursing as coordinator of the patient journey and overseer of quality, within a system that privileges medical knowledge over nursing knowledge. In other words, nursing work and nursing decision making (even well planned and systematised decisions) have remained subsidiary to medicine, and the covert, hidden nature of this relationship has thus rendered the totality of the care pathway assumed and, therefore, invisible.

In everyday practice, therefore, two patterns of shared decision making emerge strongly. First, decisions about individual patients are usually made in isolation, with different decisions being made at different stages by different members of the team, with ultimate authority being awarded to the medical members.[12] Importantly, these decisions may be fed back to the patient in a sporadic, retrospective fashion that gives little clue about the illness trajectory that faces them in the future.[13] Secondly, decisions about collective groups of patients (e.g. pathways in hospital, or practice protocols in primary care), are often made by a group of nominated multidisciplinary clinicians working together for a short and finite period of time, with little regard for the totality of care needs as they fluctuate over time.[14] These protocols often form the basis for 'defensive practices' such as overemphasis on record keeping and management of physical risk factors, which seem to result from a climate of litigation risk, rather than a concern for the overall quality of care.[15]

What is at issue here for both clinicians and patients is illustrated in Box 4.1, an anonymised amalgamation of many clinical incidents involving different people at different times.

Three issues emerge as being important here. First, the lack of integration between decisions made by different members of the team at different times is evident in the experiences of Alf and his family for whom decisions about diagnostic referrals, readmission, and discharge from hospital were made in isolation from each other. Second, highly specialised, segmented aspects of care were addressed using current nationally agreed guidelines; for example, Alf was

seen by a tissue viability specialist nurse during his hospital stay who instigated a treatment plan based on clinically agreed protocols for the management of pressure ulcers. The fact that each individual member of the team followed agreed best practices made it difficult for Alf's family to complain following Alf's death; each professional group was found to have acted in an accountable, professional manner. Third, the resulting invisibility of the lack of integration, and lack of regard for the patient journey, made an analysis of the overall structural and organisational issues impossible, thus silencing the voices of clinicians who wished to see change. We now turn to these issues.

BOX 4.1 Alf Brown

Alf Brown, a 51-year-old man, who lives with his wife, was diagnosed with COPD two years ago, following a working life in the coalmines. Lately, he suffered with pain, breathlessness, mobility problems, faecal incontinence and pressure ulcers associated with end-stage COPD and was readmitted to Ward 1 for treatment of a chest infection. Once there, he was treated with antibiotics and diuretics but his general condition had deteriorated and he wished to return home to spend his last days with his family. Alf was unknown to the district nursing team until a faxed referral was received from Ward 1, alerting them to Alf's discharge from hospital that same day (a Friday). Equipment and services were unavailable out of hours, and the patient's family tried their best to care for him at home. Sadly, Alf suffered a difficult and complex death at home just days later. The last four days of Alf's life were characterised by breathlessness and panic, difficulty in managing incontinence and exudate from the pressure ulcers, and frightening hallucinations associated with screaming, sweating and difficulty sleeping. Alf's family was very angry with the community staff for allowing him to suffer, and expressed bitterness that they were left to cope in such difficult circumstances.

THE ORGANISATION OF HEALTHCARE AROUND SPECIALIST SKILLS

Historically, Alf's care might have been coordinated by 'Matron' who had a concern not just for the work being done but also its overall quality. Questions about a replacement for the hierarchical, covert coordination role held by matrons have been met with calls for less top-down leadership in which all qualified nurses share individual accountability and autonomy for their practice.[16] At issue here is the emphasis given to evidence-based medicine (EBM) which both privileges medical knowledge over, sometimes, more qualitative experiential knowledge specific to nursing, and also predominantly, and often covertly, shapes decision making as the more powerful discipline.[17] In response to this, *The New NHS: modern, dependable*, urged nurses and other clinicians to work more collaboratively with more flexible approaches to role boundaries while at the same time establishing clear lines of accountability for quality of care.[18]

In its pursuit of a way of articulating the management of the patient journey, and the quality and management of care within that journey, the professionalisation of nursing has been characterised by debates about the need for a specialist body of knowledge that recognises the experiential aspect of care, and a way of articulating that knowledge in a way that was substantively different from medical objectification and dominance over the 'dependent patient'.[19] In other words, nursing as a profession needed to find a new way of exercising its new-found specialist body of knowledge that did not involve 'telling people what to do', but that simultaneously challenged the gendered subordination of a predominantly female workforce. This is a difficult task since nursing traditionally 'fills in the gaps' left in what Williams and Sibbald call 'ambiguous spaces' between the prevailing configuration of services attached to medicine.[20] Attempts to formalise this role have led to considerable pressure to undertake work formerly carried out by medical staff. While this represents a great opportunity for nursing, it has also resulted in uncertainty about role demarcation, autonomy and legal responsibility. Responses to this have emerged in the development of specialist roles, largely formulated around disease specific, medical specialties and focused on technical, diagnostic and pharmacological-based treatment skills.[21]

Two dangers emerge here as the nurse develops an increasing array of technical and specialist skills. First, the focus on individual performance does not equate with influence over wider issues; in fact, there may be a 'distinct lack of empowerment for effective managerial decision making and nursing control'.[22] Concerns over individual, specialist skills do little to challenge the organisational and structural limitations that are placed on patient care, as evidenced in Alf's vignette. Here, events were associated with a failure to refer Alf to a community team much sooner in his care trajectory, poorly coordinated weekend discharge from hospital, unsystematic processes of care which struggled to adapt to the patient's unusual physiology (particularly allergies to standard treatments), lack of integration, lack of information, lack of emergency equipment, as well as perceived lack of support from a line manager whose own clinical background was not in community nursing. Most of these factors seem to be organisational, structural and process oriented: areas that traditionally lie outside of nursing's sphere of influence.

The team members, who suffered anxiety and stress as a result of this incident, were advised by their manager to undertake clinical supervision. This helped them to internalise and take responsibility for 'their shortcomings' in not providing this patient with a 'good death'. This reinforcement of the *individual* burden of responsibility led to depression and clinical stress in some members of the team, which in turn led to high sickness levels, high staff turnover, increased clinical errors and an overall deterioration in staff morale. Although 'reflection-in-action' is seen as being a central tool in the professional armoury of nursing,[23] that reflection can be limited to questions about 'what *I* could have done differently', reinforced by the drive towards individual accountability

in nursing, and contributing to the lack of empowerment felt by nurses. This often leads to the covert power games that constrain reflection-in-action, and relegates it to 'reflection-in-your-own time'. This then underlines the personal responsibility of nurses in the face of structural and organisation constraints to the delivery of good quality care where a more appropriate question might be: 'What could *we* have done differently?'[24]

Second, the focus on specialist skills failed to take into account the patient journey and the ways in which essential care needs (more of which later) fluctuated over time. The fact that all this occurred against a backdrop of the professionalisation of nursing, a proliferation of specialist nursing roles (in the form of, for example, tissue viability nurse specialist, respiratory specialist nurse, palliative care specialist), and a claimed erosion of the subordination of nurses within medicine, gives little comfort to Alf and his family who were failed at every stage of the patient journey. For example, Alf's pressure ulcers (which caused so much pain and distress) were managed using a specialist, rather than a systems approach. It is generally accepted that nurses are responsible for pressure ulcers; this collective responsibility was first documented by Florence Nightingale who argued that it was the fault of the nurses if they developed.[25] Certainly, some pressure ulcers arise from a failure to perform what are seen as basic nursing duties.[26]

These omissions can lead to individual nurses being held to account in official complaints, in litigation and to being charged with contravening the profession's Code of Conduct.[27] While there is no doubt that using nurses as scapegoats is too simplistic an approach,[28] the nursing profession's Code of Conduct stresses each individual nurse's accountability for not just an *action* but also an *omission*. We are not arguing for the abolition of specialist skills here; merely that in themselves they are not sufficient to achieve the vision for patient-centred care outlined earlier. Each specialisation will no doubt have its own protocols and plans demonstrating a degree of systematisation, but systematisation within a discipline or a specialism serves little purpose for the streamlining of care as a whole. The unarguable fact that decisions are a function of power differentials between nursing and medicine and that these differentials are acted out covertly, renders 'clear lines of responsibility and accountability in the overall quality of clinical care'[29] an impossible objective. What is required is a collective, whole systems approach to care in which specialist skills and outcomes are an integral part of a patient journey. But this is no easy task without a mechanism for discussing what underpins those roles and responsibilities in relation to beliefs and understandings about healthcare.

THE MEANINGS ASCRIBED TO HEALTHCARE

Increasingly, clinicians will express their understanding of 'healthcare' in relation to their specialist skills and contributions. The obsession with specialisation

can be located in a profession that sees the attributes of the medical profession (that is largely curative focused) as being desirable. But for Alf and his family, 'healthcare' constituted a journey which began on his admission to hospital and ended in his difficult death with 'no one professional who understands or is accountable for the process of care the patient experiences, or indeed the outcome of that process'.[30] But nurses already know there is more to patient-centred care than episodic specialities. One of the commonly identified reasons for the move away from purely task-based styles of organisation referred to earlier was the accusation that the individual needs of patients are largely ignored, a criticism articulated by those concerned with the delivery of 'patient-centred care' that is responsive to individual, changing needs.[31]

For this reason, Kitson outlines a vision which identifies an appreciation of patient-centred care as being the major driver for sustained change in the health service in which *care* is given equal status to *cure*.[32] The development and deployment of specialist knowledge and professional skills about *collective* care is sometimes argued to be at odds with the unique contribution of nursing to be entirely responsive to the *individual* needs of patients as they fluctuate over time. But what increasingly emerge as important are skills in coordinating and integrating the deployment of specialist skills in ways that empower the patient and take into account the patient journey in its entirety as well as the quality of its essential elements. For example, 'Essence of Care', a Department of Health funded benchmarking exercise that arose from a concern to 'get the basics right', focuses on improving the experience of patients via developments in 10 areas including communication, pressure ulcers, privacy and self-care.[33] The challenge for nursing is to find ways of managing both collective and individual needs in a way that manages the contextual and structural elements of care delivery and planning.

IMPLICATIONS FOR CLINICAL WORK

One of the questions associated with specialisation and role blurring is concerned with shared accountability. Accountability is at the heart of a drive towards clinical governance in the UK. Nurses, like any members of a profession, have always been accountable to their own professional regulating body, but there is an increasing need for a new, collective responsibility and accountability.

The literature addresses both 'downward' accountability (to the local community or to individual patients), and 'upward' accountability (to the NHS hierarchy). However, neither of these is possible without first putting in place mechanisms for establishing and maintaining horizontal accountability across multiprofessional teams, wards and general practices.[34] Scott asserts that this requires a 'cultural shift on the part of practising clinicians towards more open and impartial evaluation of clinical care and its outcome'.[35]

Of course. the cultural climate and the beliefs and values we hold about

our work are directly related to the subsequent organisation of that work. So, the way in which relationships with medicine are constructed will influence a nurse's ability to act as an advocate for Alf. These relationships have been the subject of interest for some time; what is missing is a mechanism for enacting the cultural shift so that it becomes both a process and an outcome. This calls for nurses and nursing to 'place caring at the centre of all we plan and do in the National Health Service'[36] and ultimately to reconstruct our ideas about what it means to be a member of a profession. It requires a shift from 'telling' towards a shared 'listening' in which the needs and priorities of the individual is paramount, and leadership is a concern shared by all nurses.

In such a change nurses are given the tools to take responsibility for planned changes in their practices in a way that gives them ownership, a sense of agency, and pride in their work. And these tools include well designed integrated care pathways which are based on best evidence and reflect professional consensus. The authority of integrated care pathways takes over from the authority of Sister but in a way that makes explicit the beliefs and values that we are talking about. Pathways give us the mechanism by which to negotiate the type of involvement, ownership, control and authority that is inherent in Kitson's vision.

Accountability for improvements in patient-centred care as an end in itself focus on the standardisation of practice via guidelines such as those provided in National Service Frameworks.[37] However, Kitson's argument highlights the need to focus on the *means* to that end, such as improved leadership, ownership and control. At heart here is the way in which a 'profession' is construed. Much of the literature cites the tension between the negative attributes of profession (e.g. self-interest and competition) and the more altruistic elements of patient-centred care (e.g. compassion and continuity).[38] Rather than force ourselves into a construction of profession that is inconsistent with our commitment to patient-centred care, we need a reconceptualisation of the nature of profession in which care is organised around competencies, the patient journey and essences of care. Care organised in this way would be based on explicit negotiation of aims, roles and responsibilities, which define us as contributors to a team, rather than as solo players with specialist concerns. The core values of patient-centred care would be defined and redefined within this forum based on shared evaluation, including the perspective of the patient and their family, so that recognition could be given that Alf and his family had a much bigger role to play, much earlier on in his care trajectory.

IMPLICATIONS FOR ALF, HIS FAMILY AND HIS CLINICIANS

Is this all unattainable dreaming? In Alf's care, the local palliative care team was awarded some funds to invest in the introduction of the Liverpool Care Pathway for the Dying.[39] Some of the community and respiratory specialist nurses volunteered to act as champions for a pathway development because

they recognised the chance to understand and deal with some difficult issues. There was some resistance to the pathway among medical staff (and some community nurses), but overall its introduction allowed the team to manage difficult and complex cases so that good deaths became the norm, not the exception. Patient and family satisfaction rose, multidisciplinary working relationships improved, communication and coordination improved, and staff turnover and sickness rates reduced.

For the nurses, pathways added another layer onto essence of care statements about actions and quality by placing a sense of order and rhythm onto the tasks. For example, instead of being told 'Improve the maintenance of dignity for patients' (as in essence of care benchmarking), pathways outline the sequence of events, by whom, in what order, to what level of quality, cost, and outcome, so that dignity can be maintained within a supportive context. This is important; without clear, definable shared goals and objectives, it is very difficult for nurses today to know when they have 'done a good job'. The nurses involved in the vignette reported that using the pathway helped them to plan their own goals (instead of remaining passive and invisible) and demonstrate when and how well they had achieved them.

Of course, the flip side to this is that non-achievement of the activities in the pathway can be used as a performance management tool in a punitive way. However, even this was welcomed by the nurses who felt that a clear, transparent measure of performance helped to remove the fear of an imminent, invisible and indefinable Sword of Damocles.[40] Allaying the concerns of the GPs about 'trusting' the community nurses to follow the guidelines for drug administration in the home took major time and effort. But its net effect was much greater than implementation of the pathway itself; once nurses had proved they could work within the pathway and could do so in a safe and timely manner, they began to be involved in decision making about other matters and were given a greater stake in the running of the organisation.

In a wider sense, pathways that are fundamentally based on patient-centred care and the patient journey have the capability of giving nursing the structure needed to develop visibility and transparency about what we do (i.e. the unique nature of nursing and essences of care), and how well we do it (concerns about quality). The processes involved in constructing and implementing a pathway inherently side-step the hidden decision making and ambiguities that make up so much of nursing work. By being involved in the meetings and decision making that are necessary to action a pathway, nurses can show the sort of ownership, authority and leadership that Kitson and others call for. The defining nature of a profession, using this model, is the ability to construct a collaboratively agreed pathway and to act on it in an individualised way that takes into account the patient's need for privacy, dignity and the essences of care identified earlier. Thus, patient-centred care and systematisation are seen as mutually dependent world views, rather than mutually antagonistic.

THE FUTURE FOR NURSING AND SYSTEMATISATION

In the debate over professional autonomy and control, it has been argued that the medical profession has resisted systematisation because it fears that the explicit setting out of its work makes it possible 'for forces outside the profession to codify and regulate the labour process'.[41] This debate often focuses on the need to deliver 'individualised' care that is in every case unique and therefore incapable of being described and planned before it happens. This fear has, arguably, led to the maintenance of mystique around everyday professional practice, the monopolisation of indeterminate elements of practice and the delegation of routine elements to nurses. These routine elements, however, lend themselves to systematisation (such as assessment tools, the nursing process, primary nursing) which perhaps has been unwittingly used as a further method to maintain the subordination of nursing.

Yet, all nurses know that even these 'routine elements' require skill and individual judgement about the essences of care such as privacy and dignity that cannot be easily systematised. So the dilemma facing nursing is that its commitment to making visible what it does, and to what level of quality, potentially shifts control to external *elements*, thus making nursing more, not less, vulnerable to encroachments of management (including financial) control, and to the power differentials between medicine and nursing. However, as Alf's care demonstrates, it is not the *elements* of care that define nurses as professionals but the ability and competency to put those collective elements together into a *process* that is individual patient-centred care. Beil-Hildebrand argues that medical clinicians resist systematisation in order to maintain their professional privilege, status and power.[42] **Collective** systematisation, via the use of integrated care pathways, provides a middle ground in which to articulate, and negotiate, individual contributions in a way that breaks down barriers of professional self-interest. It is only then that we can truly develop and deliver the essences of patient-centred care in a way that is visible, valued and respected.

The professionalisation of nursing, with its unique knowledge base, its commitment to quality assurance, to the transparent organisation and planning of care, places nursing at the forefront of the clinical governance agenda. While the literature on clinical governance and accountability is heavily critical of the lack of specificity and the lack of guidance on the blurring of role boundaries, this represents a golden opportunity for nursing to lead the way to achieve collegiate, patient-centred, quality-assured care that allows for true systematisation of the patient journey. However, despite nursing's clear allegiance with systematisation in its various guises, historical gendered divisions of labour and decision making patterns continue to muddy the waters in clinical practice. Despite legal and professional calls for accountability, nurses all too often find themselves in positions as covert, hidden custodians of individual patient-centred care with very little input into more collective

strategic decision making. Pathways have the potential to allow for open discussion and negotiation that allow for patient-centred care to be placed at the heart of systematisation, which then becomes a mechanism, rather than a barrier, to achieving Kitson's vision. We began this chapter with the recognition that an empowered, autonomous nursing workforce and patient-centred care are inextricably linked – integrated pathways give us the tools to achieve both in an open, explicit manner.

ACKNOWLEDGEMENT

We wish to thank Linda Newton (Palliative Care Specialist Nurse) for her comments on an earlier draft.

REFERENCES

1 Kitson A. Nursing leadership: bringing caring back to the future. *Quality in Health Care*. 2001; **10**: 79–84.
2 Wolf ZR. *Nurses' Work, the Sacred and the Profane*. Philadephia: University of Pennsylvania Press; 1988. Wicks D. *Nurses and Doctors at Work: rethinking professional boundaries*. Buckingham: Open University Press; 1998. Savage J, Moore L. *Interpreting Accountability: an ethnographic study of practice nurses, accountability and multidisciplinary team decision-making in the context of clinical governance*. Research report, London: Royal College of Nursing; 2004.
3 Reed J, Watson D. The impact of the medical model on nursing practice and assessment. *Int J Nursing Studies*. 1994; **31**(1): 57–66.
4 Kitson, op. cit.
5 Wicks, op. cit. Porter S. *Nursing's Relationship with Medicine*. Aldershot: Avebury Publishing; 1995.
6 Wolf, op. cit. Wicks, op. cit.
7 Department of Health. *A Strategy for Nursing: a report from the Steering Committee*. London: Department of Health Nursing Division; 1989. Ersser S, Tutton E. Primary nursing: a second look. In: Ersser S, Tutton E, eds. *Primary Nursing in Perspective*. 2nd ed. Oxford: Scutari Press; 1991. pp. 3–30. Rafferty D. Team and primary nursing. *Senior Nurse*. 1992; **12**(1): 31–4.
8 Arnold D. Nursing and power-use of the so-called poststructuralism theory for the analysis of the power-relationships in the 'female' nursing professional. *Pflege*. 1996; **9**(1): 72–9. Savage, Moore, op. cit.
9 Savage, Moore, op. cit.
10 Wicks, op. cit.
11 Ibid.
12 Savage, Moore, op.cit.
13 Close H, Procter S. Coping strategies used by hospitalised stroke patients: implications for continuity and management of care. *J Advanced Nursing*. 1999; **29**(1): 138–44. Close H. Roles and responsibilities in understanding, accepting and adapting to an uncertain chronic illness trajectory. Unpublished PhD Thesis, Northumbria University; 2005.

14 Dowswell T, Wilkin D, Banks-Smith J. Nurses and English primary care groups: their experiences and perceived influence on policy development. *J Advanced Nursing*. 2002; **37**(1): 35–42.
15 Wiener C, Kayser-Jones J. Defensive work in nursing homes: accountability gone amok. *Social Science and Medicine*. 1989; **28**(1): 37–44. Annandale E. Working on the front-line: risk culture and nursing in the new NHS. *Sociological Review*. 1996; **94**(3): 416–51.
16 Kitson, op. cit.
17 Savage, Moore, op. cit.
18 Department of Health. *The New NHS: modern, dependable*. London: HMSO; 1997.
19 Beil-Hildebrand M. Theorising culture and culture in context: institutional excellence and control. *Nursing Inquiry*. 2002; **9**(4): 257–74.
20 Williams A, Sibbald B. Changing roles and identities in primary health care: exploring a culture of uncertainty. *J Advanced Nursing*. 1999; **29**(3): 737–45.
21 Beil-Hildebrand, op. cit.
22 Lewis M. Flogging the dead horse: the myth of nursing empowerment? *J Nursing Management*. 2000; **8**: 209–13 (quotation from p. 212).
23 Schon DA. *The Reflective Practitioner*. London: Jossey Bass: 1991.
24 Mantzoukas S, Jasper MA. Reflective practice and daily ward reality: a covert power game. *J Clinical Nursing*. 2004; **13**: 925–33.
25 Nightingale F. *Notes on Nursing: what it is and what it is not*. London: Duckworth & Co.; 1970.
26 Moore D. The buck stops with you. *Nursing Times*. 1987; **83**(39): 54–6.
27 Department of Health. Abstract from the Select Committee Report in relation to the Health Service Ombudsman Report for 1994–95. *J Tissue Viability*. 1996; **6**(3). Bhomick BK. Management of pressure sores – who's responsible? *Geriatric Medicine*. 1992; **16**: 19. Dimond B. Pressure sores: a case to answer. *Brit J Nursing*. 1994; **3**(14): 721–7. Taylor JS. Malpractice implications of pressure ulcers. *Advances in Wound Care*. 1994; **7**(5): 43–8.
28 Anthony D. The treatment of decubitus ulcers: a century of misinformation in the textbooks. *J Advanced Nursing*. 1996; **24**: 309–16.
29 National Health Service Executive. *Clinical Governance: quality in the new NHS*. London: HMSO; 1999.
30 Scott I. Clinical governance: an opportunity for nurses to influence the future of healthcare development. *NT Research*. 1999; **4**(3): 170–6 (quotation from p. 171).
31 Pembrey S. The development of nursing practice: a new contribution. *Senior Nurse*. 1989; **9**(8): 3–8.
32 Kitson, op. cit.
33 National Health Service Clinical Support Governance Team. Essence of Care Programme, 2006. http://www.cgsupport.nhs.uk/Programmes/Essence_of_Care_Programme/default.asp (accessed 3 October 2006).
34 Allen P. Accountability for clinical governance: developing collective responsibility for quality in primary care. *BMJ*. 2000; **321**: 608–11.
35 Scott I. Time for a collective approach from medical specialists to clinical governance (editorial). *Int Med J*. 2003; **32**: 499–501 (quotation from p. 499).
36 Kitson, op. cit.

37 Burnhope C, Edmonstone J. 'Feel the fear and do it anyway': the hard business of developing shared governance. *J Nursing Management*. 2003; **11**: 147–57.
38 Beil-Hildebrand, op. cit.
39 Marie Curie. Liverpool Care Pathway for the dying patient (LCP). http://www.lcp-mariecurie.org.uk (accessed 5 January 2005).
40 Annandale, op. cit.
41 Beil-Hildebrand, op. cit.
42 Ibid.